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## GENERAL INFORMATION

John Sklar, M.D.

## Travelers Indemnity Company of Connecticut

M4-16-3652-01

## Box Number 5

August 11, 2016

**Requestor's Position Summary:** "99456 W5 WP MMI = \$350.00  
IR – UPPER EXTREMITY = \$300.00  
IR – LOWER EXTREMITY = \$150.00  
IR – HEAD = \$150.00  
IR – CHEST = \$150.00  
TTL = \$1100.00"

**Amount in Dispute: \$150.00**

**Respondent's Position Summary:** "Per Rule 134.204(j)(4)(C), a maximum of three musculoskeletal body areas may be billed. The Carrier reimbursed the Provider \$350.00 for the Maximum Medical Improvement evaluation \$300.00 for the impairment rating assigned by range of motion to the cervical and lumbar spine (the first musculoskeletal body area), \$150.00 for the impairment rating assigned by range of motion to the left arm and shoulder (the second musculoskeletal body area), and \$150.00 for the impairment rating assigned by range of motion to the right knee (the third musculoskeletal body area) for a total reimbursement of \$950.00."

**Response Submitted by:** Travelers

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 5, 2016	Designated Doctor Examination (99456-W5-WP)	\$150.00	\$150.00

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
  - 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.024(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
  - 863 – Reimbursement is based on the applicable reimbursement fee schedule.
  - 947 – Upheld no additional allowance has been recommended.

## **Issues**

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

## **Findings**

1. The requestor is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating for four units.

Per 28 Texas Administrative Code §134.204(j)(3), “The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is \$350.00.

28 Texas Administrative Code §134.204(j)(4) states that:

- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
  - (i) Musculoskeletal body areas are defined as follows:
    - (I) spine and pelvis;
    - (II) upper extremities and hands; and,
    - (III) lower extremities (including feet).
  - (ii) The MAR for musculoskeletal body areas shall be as follows.
    - (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
    - (II) If full physical evaluation, with range of motion, is performed:
      - (-a-) \$300 for the first musculoskeletal body area; and
      - (-b-) \$150 for each additional musculoskeletal body area.
- (D) ...
  - (i) Non-musculoskeletal body areas are defined as follows:
    - (I) body systems;
    - (II) body structures (including skin); and,
    - (III) mental and behavioral disorders.
  - (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides...
  - (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation finds that the requestor performed impairment rating evaluations of chest, head, thoracic spine, lumbar spine, cervical spine, left wrist/arm, left shoulder, and right knee. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) addresses the chest in the respiratory system chapter and the head in the nervous system chapter. For this reason, they are considered body systems in the non-musculoskeletal category. Therefore, the correct MAR for this examination is \$900.00.

The total MAR is calculated as follows:

Examination	AMA Chapter	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement			\$350.00
IR: Cervical Spine (ROM)	Musculoskeletal System	Spine & Pelvis	\$300.00
IR: Thoracic Spine (ROM)			
IR: Lumbar Spine (ROM)		Upper Extremities	\$150.00
IR: Left Wrist/Arm (ROM)			
IR: Left Shoulder (ROM)		Lower Extremities	\$150.00
IR: Right Knee (ROM)			
IR: Head	Nervous System	Body Systems	\$150.00
IR: Chest/Ribs	Respiratory System	Body Systems	\$150.00
<b>Total MMI</b>			<b>\$350.00</b>
<b>Total IR</b>			<b>\$900.00</b>
<b>Total Exam</b>			<b>\$1,250.00</b>

2. The total MAR for the disputed services is \$1250.00. The insurance carrier paid \$950.00. The requestor is seeking \$150.00. This is the amount recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

### ***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____	_____
Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	September 1, 2016 Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**